Mason General Hospital & Family of Clinics

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

PURPOSE

Mason General Hospital and Family of Clinics (the "District") is committed to the provision of emergency health care services to all persons in need of medical attention regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care, consistent with the requirements of Washington Administrative Code 246-453, are established. These criteria will assist staff in making consistent and objective decisions regarding eligibility for charity care while ensuring the maintenance of a sound financial basis.

The written policy includes: (a) eligibility criteria for charity care, (b) describes the basis for calculating amounts charged to patients eligible for charity care (c) describes the method by which patients may apply for charity care and (d) describes how the District will publicize the policy with the community serviced by the District.

POLICY

Financial assistance may cover all appropriate hospital-based medical services, received in the hospital inpatient or outpatient/clinic setting. Services not qualifying under financial assistance may include transportation costs, elective procedures, or separately billable professional services provided by the hospital's medical staff. Non-residents of Washington State are eligible for Financial Assistance consistent with Washington Administrative Code 246-453-060, which includes emergent, non-scheduled services only.

ELIGIBILITY CRITERIA

Charity care is generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g. auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

The medically indigent patient will be granted charity care regardless of race, color, sex, religion, age, national origin, or immigration status.

Effective Date: 3/7/2013
Review Date: 10/1/2014
Revision Date: 10/20/2014
Formulated Date: 12/31/2005

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In those situations where appropriate primary payment sources are not available, patients shall be considered for charity care under this District policy based on the following criteria consistent with requirements of WAC 246-453-040 and WAC 246-453-050:

A. The full amount of hospital and/or clinic charges will be determined to be charity care for a patient whose gross family income is at or below 100% of the current federal poverty guidelines (consistent with Washington Administrative Code 261-14-027).

B. A sliding fee scale shall be used to determine the amount which shall be written off for patients with incomes between 101% and 400% of the current federal poverty level. All resources of the family as defined by the Washington Administrative Code 246-453 are considered in determining the applicability of the sliding fee scale in **Attachment A.**

C**.** The sliding fee schedule shall take into account the potential necessity for allowing the responsible party to satisfy the maximum amount of charges for which the responsible party will be expected to provide payment over a reasonable period of time, without interest or late fees.

CATASTROPHIC CHARITY CARE

The District may also write off as charity care amounts for patients with family income in excess of 400% of the federal poverty standards or at a higher percentage for those above 100% of the poverty guidelines, when circumstances indicate severe financial hardship or personal loss. This will be done only upon recommendation by the patient accounts representative or Director, Business Office with adequate justification and only upon approval by the Chief Financial Officer and the District's Board of Commissioners.

PROCESS FOR ELIGIBILITY DETERMINATION

Initial Determination

For the purpose of reaching an initial determination of eligibility, the District shall rely upon information provided orally or in written form for charity care as outlined in **Attachment B**. The District may require the responsible party to sign a statement attesting to the accuracy of the information provided to the District for purposes of the initial determination of eligibility. Pending final eligibility determination, the District will not initiate collection efforts or requests deposits, provided that the responsible party is cooperative with the District's efforts to reach a determination of sponsorship status, including return of applications and adequate documentation.

The District shall use an application process for determining initial interest in and qualification for charity care. Should patients not choose to apply for charity care, they shall not be considered for charity care unless other circumstances become known to the District.

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Final Determinations

Charity care forms, instructions, and written applications shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. Applications, whether initiated by the patient or the hospital and/or clinics should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purpose of verifying income:

1. W-2 withholding statements for all employment during the relevant time period;

2. Pay stubs from all employment during the relevant time period;

3. An income tax return from the most recently filed calendar year;

4. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance (denial for Medicaid purely on the basis of failure to apply timely will never be sufficient documentation by itself), if applicable;

5. Forms approving or denying unemployment compensation; or

6. Written statements from employers or welfare agencies. Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, the District may pursue other sources of funding, including Medicaid.

7. In the event that the patient is not able to provide any of the documentation described above, the District shall rely upon written and signed statements from the patient for making a final determination of eligibility for purposes of granting charity care.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. This process will be determined by the District and will take into consideration seasonal employment and temporary increases and/or decreases of income. Applications will be processed within 14 days of receipt of the application to the Business Office.

Charity Care will be granted based on the approval guidelines as outlined in **Attachment A**.

Income verification is required as outlined in **Attachment C**

For elective services not covered please contact the respective clinic.

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Review Date: 10/1/2014
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Approvals

Charity care applications will be approved once all required information is received and the income guidelines for granting charity care have been met. Applications will be processed within 14 days of receiving the application in the Business Office.

Eligibility on a completed and approved application is valid for eligible services received within the subsequent ninety (90) days from application approval date and will be retroactive for eligible services for all dates of service that the charity care is being granted. Approved charity care for eligible services rendered in a District clinic(s) will be valid within the subsequent 180 days from application approval date and retroactive to the dates of service for which charity is being granted.

In the event that a responsible party pays a portion of all of the charges related to appropriate hospital-based medical care services, and is subsequently found to have met the charity care criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within thirty days of achieving the charity care designation.

Time Frame for Final Determination and Appeals

The District shall provide final determination within fourteen (14) days of receipt of all application and documentation material.

Denials

Denials will be written and include instructions for appeal or reconsideration as follows. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income and family size to the Patient Accounts Representative within (30) calendar days. After the first fourteen (14) days of this period, if no appeal has been filed, the hospital may initiate collection activities.

If the District has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized. All appeals will be reviewed by the Patient Accounts Representative and the Director, Business Office

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If this determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

DOCUMENTATION AND RECORDS

A. Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.

B. Documents pertaining to charity care shall be retained for five (5) years.

PROCESS FOR COMMUNICATION

The District's charity care policy shall be publicly available in the following ways:

A. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined eligible for charity care.

B. Signage indicating the District's participation in a charity care program shall be openly posted in public areas of the Hospital and Clinics.

C. The District will provide written notice of District's charity care policy to patients upon request.

D. Both written information and verbal explanation shall be available in any language spoken by more than ten percent (10%) of the population in the District's service area. The District has identified Spanish language to be included in this context.

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ATTACHMENT A

Mason General Hospital & Family of Clinics Percentage of Sliding Fee Scale - 2014

Family Size	Federal Poverty Level[1]													
	100%	101% - 140%		141% - 180%		181% - 220%		221% - 260%		261% - 300%		301% - 340%		341% - 400%	
1	$11,670	$11,670	$16,338	$16,338	$ 21,006	$21,006	$ 25,674	$25,674	$ 30,342	$ 30,342	$ 35,010	$ 35,010	$ 39,678	$ 39,678	$ 46,680
2	$15,730	$15,730	$22,022	$22,022	$ 28,314	$28,314	$ 34,606	$34,606	$ 40,898	$ 40,898	$ 47,190	$ 47,190	$ 53,482	$ 53,482	$ 62,920
3	$19,790	$19,790	$27,706	$27,706	$ 35,622	$35,622	$ 43,538	$43,538	$ 51,454	$ 51,454	$ 59,370	$ 59,370	$ 67,286	$ 67,286	$ 79,160
4	$23,850	$23,850	$33,390	$33,390	$ 42,930	$42,930	$ 52,470	$52,470	$ 62,010	$ 62,010	$ 71,550	$ 71,550	$ 81,090	$ 81,090	$ 95,400
5	$27,910	$27,910	$39,074	$39,074	$ 50,238	$50,238	$ 61,402	$61,402	$ 72,566	$ 72,566	$ 83,730	$ 83,730	$ 94,894	$ 94,894	$ 111,640
6	$31,970	$31,970	$44,758	$44,758	$ 57,546	$57,546	$ 70,334	$70,334	$ 83,122	$ 83,122	$ 95,910	$ 95,910	$ 108,698	$ 108,698	$ 127,880
7	$36,030	$36,030	$50,442	$50,442	$ 64,854	$64,854	$ 79,266	$79,266	$ 93,678	$ 93,678	$ 108,090	$ 108,090	$ 122,502	$ 122,502	$ 144,120
8	$40,090	$40,090	$56,126	$56,126	$ 72,162	$72,162	$ 88,198	$88,198	$ 104,234	$104,234	$ 120,270	$ 120,270	$ 136,306	$ 136,306	$ 160,360
Each Additional person	$ 4,060	$ 4,060	$ 5,684	$ 5,684	$ 7,308	$ 7,308	$ 8,932	$ 8,932	$ 10,556	$ 10,556	$ 12,180	$ 12,180	$ 13,804	$ 13,804	$ 16,240
Discount	100%	90%		80%		70%		60%		50%		40%		30%	

[1] 2014 Federal Poverty Guidelines as published in the Federal Register for the 48 Contiguous States and the District of Columbia. These guidelines are used for calculating charity care eligibility under the Revised Code of Washington (RCW) 70.170

Attachment B

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APPLICATION FOR DETERMINATION FOR ELIGIBILITY FOR UNCOMPENSATED CARE

MASON GENERAL HOSPITAL AND FAMILY OF CLINICS

901 MT. VIEW DRIVE| PO Box 1668

SHELTON, WA 98584

360-427-9547

Please complete all items Date of Request:_____

I hereby request that Mason General Hospital and Family of Clinics make a written determination of my eligibility for Uncompensated (Charity) Care services at Mason General Hospital and Family of Clinics. I understand that the information which I submit concerning my annual income and family size is subject to verification. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of uncompensated services and that I will be liable for charges for services provided.

1. NAME: _____
   First Middle Last
2. PHONE: _____
3. ADDRESS:_____
   PO Number/Street City State Zip Code
4. OCCUPATION_____EMPLOYER_____

   If unemployed, last date worked_____
5. EMPLOYER OF OTHER FAMILY MEMBERS_____
6. INCOME* TOTAL FAMILY INCOME RECEIVED FOR THE LAST 3 MONTHS_____
   Has there been other employment in the past 6 months? _____

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*Income is the total cash receipts before taxes from all sources including the patient's income and income of other family members living in the same household to include such things as wages, farm or self-employed income, public assistance, social security, unemployment compensation, alimony, child support, pensions, and other.

VERIFICATION OF INCOME

Verification of income is required for determination of eligibility of Charity Care as outlined in attachment ____

Please indicate which of the following you are attaching to this application.

Pay check stubs _____ Income Tax Form_____ Other_____

IF NO INCOME, an explanation of the circumstances for no income must be made below on how you are living on zero income

_____
_____
_____
_____

7. LIST FAMILY MEMBERS-Dependents (legal custody)

Name	Relationship	Age

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8. PATIENT CARE SERVICES INFORMATION (What services do you want considered?)
Prior Medical Service? Date(s) of service _____

List Patients who received service(s):

_____ _____

_____ _____

Medical Service not yet rendered? Type of Service(s)_____

Date(s) of service _____

List Patients who received service(s):

_____

_____

_____

Have you received care at any of the following clinics listed below:

Oakland Bay Pediatrics _____ Yes or No

MGH Eye Clinic _____ Yes or No

MGH Shelton Orthopedics _____ Yes or No

MGH Surgery Clinic _____ Yes or No

Shelton Family Medicine _____ Yes or No

Mountain View Women's Clinic _____ Yes or No

MGH Family Health Clinic _____ Yes or No

MGH Ankle and Foot Clinic _____ Yes or No

I/WE HEREBY AUTHORIZE Mason General Hospital and Family of Clinics to verify the above information including employment history and to check the information on file at the credit bureau(s) or any other source named in the application. I certify that the above information is true and accurate to the best of my

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knowledge. Further, I will make application for any assistance (Washington Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any reasonable action necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that Mason General Hospital and Family of Clinics can judge my eligibility for Uncompensated Care Services based on the established criteria on file. If any information I have given proves to be untrue, I understand that Mason General Hospital and Family of Clinics may re-evaluate my financial state and take whatever action becomes appropriate.

Applicant's Signature_____ Date of Request_____

Attachment C

Applying for Financial Assistance

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When completing an application for financial assistance, following the steps below will help expedite processing:

1. Please fill out the application completely.

2. Attach income verification documents to the application and mail to:

   Mason General Hospital and Family of Clinics
   PO Box 1668
   Shelton, WA 98584

   Or fax to: 360-427-9597

All complete Applications are processed within 14 business days of receipt and must include income verification documentation. Examples of income verification documents include:

- Payroll statements with your gross income for the past three months, including unemployment compensation.
- Payroll statements with gross income for your spouse for past three months, including unemployment compensation.
- Social Security income statements.
- A profit and loss statement if you are self-employed.
- Documents verifying Child Support payments.
- Proof of pension and retirement information, if applicable.

If you have little or no income, DSHS letter is required along with 2 letters stating how you are getting by without an income, one from patient, one from person who is helping patient.

If you have further questions about applying for financial assistance, please call Patients Accounts @ 360-427-3601.

Effective Date: 3/7/2013
Review Date: 10/1/2014
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